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PED-20 Interval Medical History

Form PED-20 was used in obtaining information that would help in identifying children in whom a postnatal medical event resulted in brain damage. On the basis of the information obtained, the reviewing physician decided whether the medical information obtained should be verified and whether the child should by recalled for further study. The first version of the form implemented into the study was undated: the form was revised in April 1960 and again in February 1962. Revision resulted in substantial alteration of the form. Data from PED-20 are available on microfilm and on work file number 6.

Data Items Referencing Form PED-20, Interval Medical History

DATA ITEM ID	ITEM IN Form	CARD NUM	FROM	TO	DATA ITEM NAME
6259....W-6			15	17	Cerebral palsy: paresis, hemi, left (1 yr, interim, 7 yr)
6260....W-6			18	20	Cerebral palsy: paresis, hemi, right (1 yr, interim, 7 yr)
6261....W-6			21	23	Cerebral palsy: paresis, mono, arm, left (1 yr, interim, 7 yr)
6262....W-6			24	26	Cerebral palsy: paresis, mono, arm, right (1 yr, interim, 7 yr)
6263....W-6			27	29	Cerebral palsy: paresis, mono, leg, left (1 yr, interim, 7 yr)
6264....W-6			30	32	Cerebral palsy: paresis, mono, leg, right (1 yr, interim, 7 yr)
6265....W-6			33	35	Cerebral palsy: paraparesis (1 yr, interim, 7 yr)
6266....W-6			36	38	Cerebral palsy: quadriplegia; diplegia (1 yr, interim, 7 yr)
6267....W-6			39	41	Cerebral palsy: quadriplegia, other (1 yr, interim, 7 yr)
6268....W-6			42	44	Cerebral palsy: ataxia (1 yr, interim, 7 yr)
6269....W-6			45	47	Cerebral palsy: diplegia, atonic (1 yr, interim, 7 yr)
6270....W-6			48	50	Cerebral palsy: dyskinesia (1 yr, interim, 7 yr)
6271....W-6			51	53	Facial; palsy (1 yr, interim, 7 yr)
6272....W-6			54	56	Brachial plexus: palsy (1 yr, interim, 7 yr)
6273....W-6			57	59	Cerebral palsy: hemiatroit (1 yr, interim, 7 yr)
6274....W-6			60	62	Cerebral palsy, mixed (1 yr, interim, 7 yr)
6275....W-6			63	65	Cerebral palsy: hypotonic (1 yr, interim, 7 yr)
6277....W-6			67	67	Cerebellitis, acute, interim
6278....W-6			68	68	Cerebral palsy, progressive disease, any epoc

INTERVAL MEDICAL HISTORY

1. PATIENT IDENTIFICATION

2. HISTORY BY AGE

3. HISTORY OBTAINED

4. DATE OF HISTORY

5. INTERVIEWER'S NAME

6. TITLE OR POSITION

7. INFORMANT

8. CURRENT RESIDENCE OF PATIENT

9. ROUTINE HEALTH CARE

10. INPATIENT HOSPITAL CARE

11. OTHER MEDICAL CARE

12. INJURY NOT TREATED BY PHYSICIAN

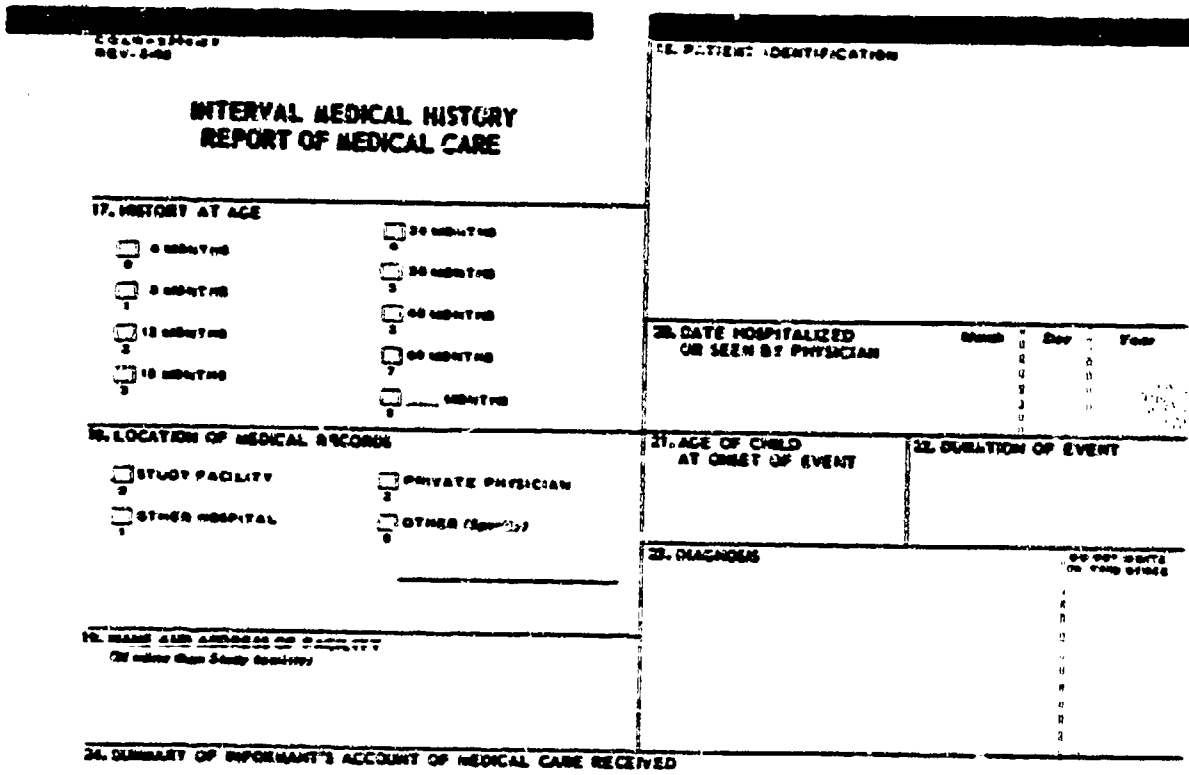
13. CONVULSION NOT TREATED BY PHYSICIAN

14. OTHER MEDICAL EVENT NOT TREATED BY PHYSICIAN

15. COMMENTS

COLLABORATIVE RESEARCH
PERINATAL RESPIRATORY BRANCH, NINDS, NIH
BETHESDA 14, MD

PED-20



INTERVAL MEDICAL HISTORY REPORT OF MEDICAL CARE

17. HISTORY AT AGE

- 0 MONTHS
- 3 MONTHS
- 12 MONTHS
- 18 MONTHS
- 24 MONTHS
- 36 MONTHS
- 48 MONTHS
- 60 MONTHS
- ____ MONTHS

18. LOCATION OF MEDICAL RECORDS

- STUDY FACILITY
- OTHER HOSPITAL
- PRIVATE PHYSICIAN
- OTHER (Specify)

19. NAME AND ADDRESS OF PARENT (If other than Study Mother)

20. DATE HOSPITALIZED OR SEEN BY PHYSICIAN — Month / Day / Year

21. AGE OF CHILD AT ONSET OF EVENT

22. DURATION OF EVENT

23. DIAGNOSIS

24. SUMMARY OF INFORMANT'S ACCOUNT OF MEDICAL CARE RECEIVED

IF NECESSARY, CONTINUE ON FORM CPD CONTINUATION SHEET

REVIEW BY STUDY PHYSICIAN: NAME _____ M.D.

25. VERIFICATION OF FORM PED-19

- NOT INDICATED
- INDICATED

26. EXAMINATION

- NOT INDICATED
- INDICATED

27. REFERRED TO

- STUDY FACILITY
- PRIVATE PHYSICIAN
- OTHER (Specify)

COLLABORATIVE RESEARCH
PERINATAL RESEARCH BRANCH, NINDS, NIH
BETHESDA, MD.

PED-20

Form Item Numbers Linked to Data Items on PED-20, Interval Medical History

ITEM ON FORM	DATA ITEM ID	CARD NUM	FROM	TO	DATA ITEM NAME
	6272....M-6		54	56	Brachial plexus palsy (1 yr, interim, 7 yr)
	6277....M-6		67	67	Cerebellitis, acute, interim
	6274....M-6		60	62	Cerebral palsy, mixed (1 yr, interim, 7 yr)
	6278....M-6		68	68	Cerebral palsy, progressive disease, any age
	6268....M-6		42	44	Cerebral palsy: ataxia (1 yr, interim, 7 yr)
	6269....M-6		45	47	Cerebral palsy: diplegia, atonic (1 yr, interim, 7 yr)
	6270....M-6		48	50	Cerebral palsy: dyskinesia (1 yr, interim, 7 yr)
	6275....M-6		63	65	Cerebral palsy: hypotonic (1 yr, interim, 7 yr)
	6273....M-6		57	59	Cerebral palsy: [illegible] (1 yr, interim, 7 yr)
	6265....M-6		33	35	Cerebral palsy: paraparesis (1 yr, interim, 7 yr)
	6259....M-6		15	17	Cerebral palsy: paresis, hemi, left (1 yr, interim, 7 yr)
	6260....M-6		18	20	Cerebral palsy: paresis, hemi, right (1 yr, interim, 7 yr)
	6261....M-6		21	23	Cerebral palsy: paresis, mono, arm, left (1 yr, interim, 7 yr)
	6262....M-6		24	26	Cerebral palsy: paresis, mono, arm, right (1 yr, interim, 7 yr)
	6263....M-6		27	29	Cerebral palsy: paresis, mono, leg, left (1 yr, interim, 7 yr)
	6264....M-6		30	32	Cerebral palsy: paresis, mono, leg, right (1 yr, interim, 7 yr)
	6267....M-6		39	41	Cerebral palsy: quadriplegia, other (1 yr, interim, 7 yr)
	6266....M-6		36	38	Cerebral palsy: quadriplegia; diplegia (1 yr, interim, 7 yr)
	6271....M-6		51	53	Facial: palsy (1 yr, interim, 7 yr)

PEDIATRIC MANUAL
INTERVAL MEDICAL HISTORY
(For Form PED-20, Rev. 2-62)

I. Introduction

This manual is a guide for the interviewer in obtaining and recording the information requested in the items listed on Form PED-20.

The purpose of Form PED-20 is to obtain information which will help identify children in whom a postnatal medical event resulted in brain damage. On the basis of the information obtained, the reviewing physician will decide whether the medical information obtained should be verified and whether the child should be recalled for further study.

II. General Instructions

A. Age Schedule. An interval history is to be obtained at ages 4, 8, 12, 18, and 24 months and annually thereafter.

B. Time-Span of History. The interval history is to cover the period from the time the child was last seen by the Study to the time of the current interview.

C. The Interviewer. The information is to be obtained and recorded by an appropriately trained lay interviewer, nurse, or social worker.

D. Informant. The information is to be obtained whenever possible from the person who has primary responsibility for the care of the child. In most cases this will be the biological mother, but in some cases this will be a mother surrogate (a person who is the functional mother).

E. Reporting. The history is for the purpose of obtaining what the informant reports and what the informant reports is to be recorded under each item. If no information is obtainable about a particular item, do not leave the item blank but write "Unk." in that space.

III. SPECIFIC INSTRUCTIONS

Item 1, Patient Identification. This item is to be completed using the child's identification stamp. The latter shall include the patient's name, NINDB number, date of birth, time of birth, sex, race, and birth weight.

Item 2, History At Age. The age-span covered by each age-level box is shown in the accompanying table.

History Age-Level	Age-Span Covered
4 months	Under 26 weeks
8 months	26-43 weeks
12 months	44-64 weeks
18 months	15-20 months
24 months	21-29 months
36 months	30-41 months

The 4 months box will be checked for infants interviewed at ages under 26 weeks. The 8 months box will be checked for infants interviewed at any age from 26 weeks through 43 weeks, etc.

Item 3, History Obtained . . . Check the appropriate box to show whether the history was obtained at a clinic or home visit, by phone or mail query, or by some other method.

Item 4, Date Of History. Record here the calendar date on which the history is obtained.

Item 5, Interviewer's Name. Record here the surname and, if necessary for positive identification, the initials of the interviewer.

Item 6, Title or Position. Use initials or abbreviations to indicate the professional training status of the interviewer (Interviewer, Nurse, Social Worker, etc.).

Item 7, Informant. If the history is obtained from the biological mother, check the box "Mother." If the history is obtained from a person other than the biological mother, check the box "Other" and specify the relationship of the informant to the child (Grandmother, Father,

Aunt, etc.). Write in the name of the informant if this information is desired by the Study institution.

Item 8, Current Address of Patient. Insert here the current address and telephone number of the patient's abode, if this information is desired by the Study institution. If child is institutionalized, give name of institution.

Item 9, Routine Health Care. Check "Yes" when the child has visited a physician or a related health practitioner for routine health supervision. Give the date of the last visit so made. Describe the nature of the visit in the "Comment" section.

Item 10, Inpatient Hospital Care. Inpatient hospital care means confinement in a hospital for a period of 24 hours or more. A "Yes" response to this item requires completion of page 2 of the form and does not otherwise require a written comment.

Item 11, Other Medical Care. Check "Yes" when the child has not been hospitalized but has been seen by a physician or a related health practitioner in an emergency room, clinic, private office, etc., for reasons other than routine health care. A "Yes" response to this item requires completion of page 2 of the form.

Item 12, Injury (Not Treated By Physician). If there is a history of injury not treated by a physician or a related health practitioner, check the appropriate box indicating the state of consciousness accompanying the injury. The box "Other" should be checked for states of disorientation, confusion, unknown states of consciousness, etc. A "Yes" response to this item requires further description under "Comments."

Item 13, Convulsion (Not Treated By Physician). A "Yes" response is called for if the informant reports convulsions, or seizures, or involuntary movements, or fits associated with disturbances of consciousness—if these have not been seen or treated by a physician or other health practitioner. A "Yes" response to this item requires further description under "Comments."

Item 14, Other Medical Event (Not Treated By Physician). Report here whether or not there has been some medical event, other than injury or convulsion, which was not treated or seen by a physician. A "Yes" response requires further description under "Comments."

Item 15, Comments. A written comment is required for each "Yes" response to items 9, 12, 13 and 14. Identify each comment by the number of the item to which it refers.

Items 16 to 27. These items are to be completed for each "Yes" response to either item 10 or item 11. (A separate page 2 is to be completed for each discrete medical event checked in item 10 or item 11.)

Item 16, Patient Identification. Same as item 1.

Item 17, History At Age. Same as item 2. The same box will be checked in this item as was checked in item 2.

Item 18, Location of Medical Records. Check the appropriate box to indicate the professional facility that may have records on the medical event being described.

Item 19, Name And Address Of Facility. If a category other than the "Study Facility" is checked in item 18, record here the name and address of the facility checked.

Item 20, Date Hospitalized Or Seen By Physician. Record here the calendar date on which the child was hospitalized or otherwise seen by a physician.

Item 21, Age Of Child At Onset Of Event. Record here the age of the child, in completed months, at which the onset of the medical event occurred for which the child was hospitalized or otherwise seen by a physician.

Item 22, Duration of Event. Record here the approximate duration of the medical event from its onset to its termination. If not

terminated, record "To the present" in this space.

Item 23, Diagnosis. Record here the diagnosis or diagnoses as given by the informant.

Item 24, Summary. Summarize in narrative form the main features of the medical event for which the child was hospitalized or otherwise seen by a physician.

Items 25 to 27. These items are to be completed by the reviewing physician after a review of the information in the foregoing items.

Item 25, Verification. Record here whether the medical event described on page 2 is to be verified. This decision will be based on the physician's assessment of the likelihood that the medical event described may have caused some brain damage. Verified information is to be reported on Form PED-29.

Item 26, Examination. Record here whether the child is to be recalled for a diagnostic examination. This decision will be based on the physician's assessment of the likelihood that this child may have had some brain damage.

Item 27, Referred To. If the decision has been made to recall the child for a diagnostic examination, record here whether the examination has been arranged for at the Study Facility, a private physician, or another medical facility. The results of the examination are to be reported on a Form CP-5, appropriately identified as to purpose, when the examination is done at the Study Facility.

[illegible]

1. PATIENT IDENTIFICATION

FOLLOW-UP INTERVAL HISTORY

2. HISTORY IN CONNECTION WITH
- 4 Month Pediatric Examination
- 8 Month Psychological Examination
- 1 Year Neurological Examination
- Other (Specify)

3. DATE OF HISTORY MO. DAY YEAR

4. INTERVIEWER'S NAME 5. TITLE OF POSITION

6. INFORMANT (Relationship to child)
- Mother
- Other (Specify) ______

FEEDING

7. NUMBER OF FEEDINGS PER DAY ______

8. MILK AND OTHER LIQUIDS FROM (Check all that apply)
- Bottle
- Cup
- Breast
- Other (Specify)

9. TYPE OF MILK (other than breast)
- [illegible]
- [illegible] (Give [illegible]) ______

10. SOLID FOODS BY SPOON
- Yes
- No (Give [illegible])

11. FEEDING PROBLEMS
- No
- [illegible] (Describe)
- [illegible] (Describe)
- Vomiting (Describe)
- Colic (Describe)
- [illegible] (Describe)
- Other (Describe)

ELIMINATION

12. NUMBER OF BOWEL MOVEMENTS PER DAY ______

13. CONSISTENCY OF USUAL BOWEL MOVEMENTS
- [illegible]
- [illegible]
- [illegible]

SLEEPING

14. USUAL DAILY PATTERN OF SLEEPING (Number of hours)

Night ______ Daytime Naps ______

15. UNUSUAL SLEEPING HABITS
- No
- Yes (Describe)

INSTRUCTIONS:

The Manual should be carefully followed in collecting and reporting this information.

Describe all unusual or abnormal conditions.

16. COMMENTS

Collaborative Perinatal Research Branch, NINDB, NIH
[illegible]

PED-20 Rev. [illegible]
Page of

FOLLOW-UP INTERVAL HISTORY

(Continued)

☐ [illegible] Month ☐ [illegible] Month ☐ 1 Year ☐ Other

ACTIVITY [illegible]

[illegible]. UNUSUAL AMOUNT OF ACTIVITY

☐ No ☐ [illegible] (Describe)

☐ [illegible] (Describe)

[illegible]. UNUSUAL TYPE OF ACTIVITY (Check all that apply)

☐ No ☐ [illegible] holding spells (Describe)

☐ Temper tantrums (Describe)

☐ Head-banging (Describe)

☐ Other rhythmic banging or rocking (Describe)

☐ Other (Describe)

CRYING

[illegible]. UNUSUAL AMOUNT OR TYPE OF CRYING

☐ No ☐ More than expected amount (Describe)

☐ Less than expected amount (Describe)

☐ Other (Describe)

[illegible]. RESPONSE TO COMFORTING. CRIES FOR LONG PERIODS IN SPITE OF ATTEMPTS AT COMFORTING

☐ No ☐ Yes (Describe)

[illegible]. PATIENT IDENTIFICATION

[illegible handwriting]

[illegible]. COMMENTS

SOCIAL RESPONSE

	Pos.	Int.	Neg.	W/A.	Unkn.
[illegible]. TO APPROACH OF MOTHER	☐	☐	☐	☐	☐
[illegible]. TO APPROACH OF OTHER FAMILIAR PERSONS	☐	☐	☐	☐	☐
[illegible]. TO APPROACH OF STRANGE PERSONS	☐	☐	☐	☐	☐
[illegible]. TO BEING HELD AND CUDDLED	☐	☐	☐	☐	☐
[illegible]. TO ROUGH PLAY	☐	☐	☐	☐	☐
[illegible]. TO BEING BATHED	☐	☐	☐	☐	☐
[illegible]. TO BEING FED	☐	☐	☐	☐	☐
[illegible]. TO BEING DRESSED	☐	☐	☐	☐	☐

KEY TO RECORDING

Pos. - POSITIVE [illegible]

Int. - INTERMEDIATE [illegible]

Neg. - NEGATIVE [illegible]

W/A. - WITHDRAWN [illegible]

Unkn. - UNKNOWN [illegible]

Collaborative [illegible]
[illegible]

PED-20 [illegible]
Page 2 of [illegible]

FOLLOW-UP INTERVAL HISTORY
(Continued)

PAST MEDICAL HISTORY

COMMENTS

FOLLOW-UP INTERVAL HISTORY
(Continued)

[illegible]

REPORT OF [illegible] HOSPITALIZATION

[illegible]

- [ ] [illegible]
- [ ] [illegible]
- [ ] [illegible]
- [ ] [illegible]
- [ ] Other [illegible]

[illegible]

- [ ] Yes
- [ ] No [illegible]

[illegible]

Month Day Year

[illegible]

DO NOT USE THIS SPACE

[illegible]

- [ ] High Fever
- [ ] Convulsions
- [ ] [illegible]
- [ ] [illegible]
- [ ] [illegible]
- [ ] [illegible]
- [ ] [illegible]
- [ ] [illegible]
- [ ] [illegible]
- [ ] [illegible]
- [ ] Operation

[illegible]

PHS-3009-20
4-60

FOLLOW-UP INTERVAL HISTORY

INSTRUCTIONS: Every numbered item should be checked (√). [illegible]. Findings should be checked (√) and described in margin at right.

1. [illegible]	2. BIRTH DATE (Mo-Day-Yr)
3. [illegible]	4. DATE (Mo-Day-Yr)

Identify remarks by number of item. Every abnormality which is checked (√) should have some description. Give reason for not evaluating any item.

A - PRESENT STATUS OF CHILD

5. MOTHER'S ESTIMATE OF INFANT'S PRESENT HEALTH

☐ NORMAL

☐ OTHER (Describe)

6. MOTHER'S COMPLAINTS REGARDING INFANT'S HEALTH

☐ NONE

☐ OTHER (Describe)

B - INFANT'S INTERVAL HISTORY

7. ILLNESSES (if more than one, describe in column at right using same numbers)

☐ NO ☐ YES (Complete items below - describe at right)

8. DIAGNOSIS ______

9. ESTABLISHED BY ______

10. TREATMENT ______

11. DURATION ______

12. COMPLICATIONS ______

13. AGE AT ONSET ______

14. SPECIFIC SYMPTOMS

15. [illegible] ☐ NO ☐ YES

16. HIGHEST TEMPERATURE ______

17. DURATION ______

18. [illegible] ☐ NO ☐ YES

19. [illegible] ☐ NO ☐ YES

DURATION ______

20. [illegible] ☐ NO ☐ YES

DURATION ______

21. CONVULSIONS ☐ NO ☐ YES

22. [illegible] ☐ NO ☐ YES

23. [illegible] ☐ NO ☐ YES

24. SIGNIFICANT WEIGHT LOSS (Five months)

☐ NO ☐ YES

[illegible], Education, and Welfare
Public Health Service

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FOLLOW-UP INTERVAL HISTORY
(Continued)

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PHS-3004-20
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SPECIFIC SYMPTOMS (Continued)

26. DEVELOPMENTAL REGRESSION ☐ NO ☐ YES

29. ANEMIA ☐ NO ☐ YES

27. OTHER ☐ NO ☐ YES

28. ACCIDENTS

☐ NONE

29. TRAUMA - HEAD ☐ NO ☐ YES

30. TRAUMA - UNCONSCIOUSNESS ☐ NO ☐ YES

31. TRAUMA - OTHER (Describe) ☐ NO ☐ YES

32. HOSPITALIZATION

☐ NONE

☐ OTHER (Describe)

33. OPERATIONS

☐ NONE

☐ OTHER (Describe)

34. RADIATION

☐ NONE

☐ OTHER (Describe)

35. IMMUNIZATIONS

☐ NONE

☐ D.P.T. _____ TIMES

☐ POLIO _____ TIMES

☐ OTHER (Describe)

36. REACTIONS ☐ NO ☐ YES

37. ELIMINATION (Bowel and bladder)

☐ NORMAL

☐ ABNORMAL (Describe)

38. ALLERGY

☐ ABSENT

☐ PRESENT (Describe)

Identify reasons by number of item. Every abnormality which is checked (✓) should have some description. Give reason for not evaluating any item.

FOLLOW-UP INTERVAL HISTORY
(Continued)

see Third Form
PHS-3004-20
rev 4-60

39. FEEDING

40. MILK _____ AMOUNT/DAY

41. SOLIDS _____ AMOUNT/DAY

42. VITAMINS ☐ 0 NO ☐ 1 YES

43. FEEDING PROBLEMS
☐ 0 ABSENT
☐ 1 PRESENT

44. DEVELOPMENTAL MILESTONES — AGE ATTAINED (IN MONTHS)

45. HEAD UP	☐ 0 NO	☐ 1 YES	45. _____
47. CHEST UP	☐ 0 NO	☐ 1 YES	47. _____
49. SAT WITH SUPPORT	☐ 0 NO	☐ 1 YES	49. _____
51. SAT ALONE	☐ 0 NO	☐ 1 YES	51. _____
53. STOOD HOLDING ON	☐ 0 NO	☐ 1 YES	53. _____
55. STOOD ALONE	☐ 0 NO	☐ 1 YES	55. _____
57. WALKED ALONE	☐ 0 NO	☐ 1 YES	57. _____
59. SAID RECOGNIZABLE WORDS	☐ 0 NO	☐ 1 YES	59. _____
61. CONDITIONED REFLEX	☐ 0 NO	☐ 1 YES	61. _____

Identify remarks by number of item. Every abnormality which is checked (1) should have some description. Give reason for not evaluating any item.

Department of Health, Education, and Welfare
Public Health Service

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PHS-[illegible]
REV. [illegible]

FOLLOW-UP INTERVAL HISTORY

1. PATIENT IDENTIFICATION

C OL R-3004-20
Rev. 3-61

INSTRUCTIONS:
The Interview Guide and the Manual should be carefully followed in collecting and reporting the data for this form.
Describe all unusual or abnormal conditions.

2. HISTORY IN CONNECTION WITH

- [ ] 4 Month Pediatric Examination
- [ ] 8 Month Psychological Examination
- [ ] 1 Year Neurological Examination
- [ ] Other (Specify)

3. DATE MO. DAY YEAR

4. INTERVIEWER'S NAME

5. STATUS

6. INFORMANT (Relationship to child)

FEEDING

7. NUMBER OF FEEDINGS PER DAY ____________

8. MILK FROM

- [ ] Bottle only
- [ ] Breast only
- [ ] Breast and bottle
- [ ] Other (Specify)

9. TYPE OF MILK ____________

10. SOLID FOODS BY SPOON

- [ ] Yes
- [ ] No (Give reason)

11. FEEDING PROBLEMS

- [ ] No
- [ ] Difficult or excessively slow (Describe)
- [ ] Excessively fast (Describe)
- [ ] Vomiting (Describe)
- [ ] Colic (Describe)
- [ ] Other (Describe)

ELIMINATION

12. NUMBER OF BOWEL MOVEMENTS PER DAY ____________

13. CONSISTENCY OF USUAL BOWEL MOVEMENTS

- [ ] Variable, soft or firm
- [ ] Watery
- [ ] Very hard

SLEEPING

14. USUAL DAILY PATTERN OF SLEEPING (Number of hours)

Night ________ A.M. Nap ________ P.M. Nap ________

15. UNUSUAL SLEEPING HABITS

- [ ] No
- [ ] Yes (Describe)

16. COMMENTS

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service

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Test Form 6-60

PHS-4604-20
REV. 6-60

FOLLOW-UP INTERVAL HISTORY
(Continued)

☐ 4 Month ☐ 8 Month ☐ 1 Year ☐ Other

17. PATIENT IDENTIFICATION

CLLR-3004-20
3-61

ACTIVITY WHEN AWAKE

18. UNUSUAL AMOUNT OF ACTIVITY

☐ No ☐ Unusually inactive (Describe)
☐ Excessively active (Describe)

19. UNUSUAL TYPE OF ACTIVITY (Check all that apply)

☐ No ☐ Breath holding spells (Describe)
☐ Temper tantrums (Describe)
☐ Head banging (Describe)
☐ Other rhythmic banging or rocking (Describe)
☐ Rumination (Describe)
☐ Other (Describe)

CRYING

20. UNUSUAL AMOUNT OR TYPE OF CRYING

☐ No ☐ More than expected amount (Describe)
☐ Less than expected amount (Describe)
☐ Other (Describe)

21. RESPONSE TO COMFORTING: CRIES FOR LONG PERIODS IN SPITE OF ATTEMPTS AT COMFORTING

☐ No ☐ Yes (Describe)

30. COMMENTS

SOCIAL RESPONSE

	Pos.	Int.	Neg.	W/A	Unkn.
22. TO APPROACH OF MOTHER	☐	☐	☐	☐	☐
23. TO APPROACH OF OTHER FAMILIAR PERSONS	☐	☐	☐	☐	☐
24. TO APPROACH OF STRANGE PERSONS	☐	☐	☐	☐	☐
25. TO BEING HELD AND CUDDLED	☐	☐	☐	☐	☐
26. TO ROUGH PLAY	☐	☐	☐	☐	☐
27. TO BEING BATHED	☐	☐	☐	☐	☐
28. TO BEING FED	☐	☐	☐	☐	☐
29. TO BEING DRESSED	☐	☐	☐	☐	☐

KEY TO RECORDING:

Pos. – POSITIVE: Consistently smiles, coos and laughs, reaches towards or actively participates.

Int. – INTERMEDIATE: Variable between positive and negative, mildly positive or negative most of the time, or Neutral, such as being alert without active participation.

Neg. – NEGATIVE: Consistently cries, avoids, resists, becomes limp or stiff.

W/A – WITHDRAWN: Completely unaware of the situation.

Unkn. – UNKNOWN: Child has not been in the situation, or informant is unable to provide sufficient information to categorize the response.

[illegible]

FOLLOW-UP INTERVAL HISTORY
(Continued)

☐ 6 Month ☐ 8 Month ☐ 1 Year ☐ Other

31. PATIENT IDENTIFICATION

[illegible]

38. COMMENTS

PAST MEDICAL HISTORY

32. THINGS TAKEN BY MOUTH *(Other than food, vitamins, and drugs which are reported on Page 4)*

☐ No ☐ Yes *(Describe)*

33. INJURY

☐ No ☐ Head injury with loss of consciousness *(Describe)*

☐ Head injury without loss of consciousness *(Describe)*

☐ Other *(Describe)*

34. ILLNESSES *(Other than "colds", diaper rash, and "teething")*

☐ No *(NOTE: All the symptoms and procedures listed on Page 4 must be inquired about. If any answered check "yes" and complete Page 4)*

☐ Yes, Number ______ *(Report on Page 4, use separate sheet for each illness)*

SOCIO-ECONOMIC ENVIRONMENT

35. DIFFICULTIES, UNUSUAL SITUATIONS, OR MAJOR EVENTS OR CHANGES IN THE HOME AND FAMILY *(Comments or none)*

☐ No ☐ Yes *(Describe)*

OTHER

36. UNUSUAL THINGS ABOUT THE CHILD NOT REPORTED ELSEWHERE

☐ No ☐ Yes *(Describe)*

QUALITY OF DATA

37. INTERVIEWER'S EVALUATION OF INFORMATION RECORDED ABOVE *(Including Page 4)*

☐ Satisfactory

☐ Incomplete because *(Describe)*

☐ Other qualifications *(Describe)*

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service

(PED-20) PAGE 3 OF 4
Year Form 4-60

[illegible]

Form HS-3004-20
REV. 4-60

FOLLOW-UP INTERVAL HISTORY
(Continued)

☐ 4 Month ☐ 8 Month ☐ 1 Year ☐ Other

39. PATIENT IDENTIFICATION

See CCLR-3009-20
rev. 3-61

REPORT OF ILLNESS OR HOSPITALIZATION

40. HOSPITAL (Name and address)

☐ No

41. PHYSICIAN (Name and address)

☐ No

42. DATE SEEN BY PHYSICIAN OR ADMITTED TO HOSPITAL ______ (Month) (Day) (Year)

43. AGE OF CHILD AT ONSET OF ILLNESS ______

44. DIAGNOSIS

45. DURATION OF ILLNESS

SYMPTOMS (Check those that apply, list others, and describe all)

46. ☐ Convulsions
67 ☐ Unconsciousness
48. ☐ Dehydration
49. ☐ Draining ear
50. ☐ Cyanotic spells
81. ☐ Other

TESTS, PROCEDURES, AND TREATMENT (Check those that apply, list others, and describe all)

52. ☐ Spinal tap
53. ☐ X-Ray or fluoroscopy
54. ☐ Operation
55. ☐ Other

56. COURSE AND COMPLICATIONS (Describe)

PED-29 Summary of Medical Records of Illness or Hospitalization

Form PED-29 was used to provide an abstract of recorded information about an illness, injury, condition or hospitalization of the child that may have caused, influenced or indicated the presence of central nervous system disorder. First implemented in January 1961, the form was never revised. Data are available on microfilm only.

COLLABORATIVE PERINATAL RESEARCH STUDY
1961

1. PATIENT IDENTIFICATION

SUMMARY OF MEDICAL RECORDS OF ILLNESS OR HOSPITALIZATION

2. SUMMARY DONE BY

3. VISIT OR ADMISSION

4. DATE OF EXAM: Mo. | Day | Year

5. SOURCE OF MEDICAL RECORDS
- 0 Study Facility
- 1 Other Hospital or Clinic
- 2 Private Physician
- 3 Visiting Nurse Service
- 4 Other (Specify)

6. NAME AND ADDRESS OF OTHER THAN STUDY FACILITY

7. RECORD NUMBER
(Local patient identification number, if any, or code if different from Item 1 above)

8. SUMMARY INCLUDES RECORDS DATED: Mo. | Day | Year | Through | Mo. | Day | Year

9. AGE OF CHILD AT ONSET OF ILLNESS

10. DURATION OF ILLNESS

11. DIAGNOSIS

12. SALIENT FEATURES OF ILLNESS OR CONDITION (Brief summary of signs and symptoms, results of tests and procedures, treatment, course and complications)

13. EXCEPTION TO SUMMARY: CHECK BELOW ALL THAT APPLY TO THIS ILLNESS.

- 13. ☐ High fever Max. _____°F.
- 14. ☐ Convulsions
- 15. ☐ Unusual drowsiness
- 16. ☐ Diarrhea
- 17. ☐ Constipation
- 18. ☐ Hearing ear
- 19. ☐ Cyanotic spells
- 20. ☐ Reaction to medicines
- 21. ☐ Spinal tap
- 22. ☐ X-ray or fluoroscopy
- 23. ☐ Operation

(Continue on Form CP-1, Continuation Sheet)

SUMMARY OF MEDICAL RECORDS OF ILLNESS OR HOSPITALIZATION
(PED-29 January 1961)

I. INTRODUCTION

The purpose of the summary of medical records is to provide in a fairly systematic way an abstract of recorded information about an illness, injury, condition or hospitalization of the child which may have caused, influenced, or indicated the presence of Central Nervous System disease. For simplicity the term "illness" as used hereafter will include:

A. Infectious, metabolic, and neoplastic diseases for which medical treatment is given.

B. Congenital or acquired malformations or conditions for which medical diagnosis or treatment is given.

C. Accidents or injuries including burns or poisonings for which medical treatment is rendered.

D. Emotional or psychiatric conditions or illnesses for which professional diagnostic or therapeutic service is rendered.

E. Any other hospitalization or outpatient clinic care for diagnosis or treatment of serious or potentially serious conditions.

In general it is not considered worthwhile for the purposes of this Study to obtain and report medical records on routine well-baby care visits, immunizations, or the diagnosis or treatment of such mild and common conditions as common cold and diaper rash.

II. SOURCE OF INFORMATION

The types of records which may be used for verifying the facts of, and providing pertinent details of, an illness in the child may include visiting nurse service records, social worker or public welfare case worker records, records of health insurance or city outpatient clinics, as well as private physicians' records and hospital inpatient or outpatient records. Any of these may be used as authorative sources for further information on the child. This is not to imply that all these possible sources must be consulted for each case.

III. PERSON DOING THE SUMMARY

1) Records from the Study hospital or outpatient facility may be abstracted by a medical records librarian or project secretary or nurse at the discretion of the local pediatrician-in-chief.

2) Records from outside sources such as other hospitals, private physicians, visiting nurse service, etc., should be abstracted by a Study pediatrician, or under his direct supervision. This is felt advisable in order that the Study pediatrician's knowledge of the idiosyncrasies of medical practice in other facilities may be used in interpreting and reporting this information.

3) This form, with a very abbreviated manual or preferably a letter of explanation, may be sent to private physician, visiting nurse, or physician-in-charge of an outpatient clinic for completion by or under the direct supervision of the professional involved.

4) In some well-supervised situations it may be desirable to send this form with an accompanying abbreviated manual or letter of explanation to the medical records librarian of another hospital rather than requesting from that hospital a discharge summary or copy of hospital records.

5) Whether to handle outside hospital records by the procedure in paragraph (2) or (3) or the procedure in paragraph (4) shall be left to the discretion of the Project Director or Pediatric Coordinator.

IV. HOW THE FORM IS STARTED

Usually the person initiating this form will be the Interval History interviewer, who obtains from the mother the history that the child was ill and was seen by a physician or in a clinic, etc. However, the use of this form should not be limited to such situations but should also include the abstract of any medical records which become known to the Study personnel.

V. CONSTRUCTION OF THE FORM

This record sheet is structured in the form of a skeleton outline of a traditional case summary:

1. Who? - Item 1
2. Where? - Items 5, 6 and 7
3. When? - Items 8, 9 and 10
4. What was the illness? - Item 11
5. How was the illness manifested?
   What did the physician do?
   What was the outcome? - Item 12.

Item 12 is to be a brief narrative summary of the illness. For this reason the space for recording this summary is not divided into discrete blocks, and provision is made for extending this summary onto additional record sheets.

January 1961

Items 11-23 are to be used as a coarse code for the presence of certain features of illness or treatment that are thought to be of special relevance to Central Nervous System disease. These items in no way restrict or limit the need for the narrative summary.

VI. INSTRUCTIONS AND DEFINITIONS FOR COMPLETING THE ITEMS ON THIS FORM

Item 1, Patient Identification. This should be completed using the patient's name plate, containing at least the following information: patient's name, NIHDB number, date of birth, birth weight, sex and race.

Item 2, Summary Done By. Here record the name of the person who abstracted the medical records and formulated this report.

Item 3, Title or Position. Here record the professional status of the person who's name appears in Item 2 (as Nurse, Medical Records Librarian, Pediatrician, etc.).

Item 4, Date of Summary. Here record the date the summary was done.

Item 5, Source of Medical Records. This item is to indicate what type of record is being summarized on this form.

The first category "Study Facility" refers to the reporting hospital inpatient, outpatient, and emergency ward services, and any other service administratively connected to the Study institution.

The second category "Other Hospital or Clinic" includes not only the inpatient, outpatient, and emergency ward services of another hospital, but also Health Insurance Plan, city, or other group pediatric outpatient clinics.

The third category "Private Physician" refers to the situation where the child was seen by the physician on an outpatient basis, and to the possible situation where the child was seen in a hospital or general clinic but the records are kept by the physician rather than by the hospital or clinic.

The fourth category "Visiting Nurse Service" refers to any public health nursing service. If the primary diagnosis and treatment for this illness were done by a visiting nurse, it is likely the Visiting Nurse Service would have a record of this. It will be more frequently the case that the Visiting Nurse Service conducts follow-up visits including observation and treatment for an illness or condition for which the child was previously seen by a physician or in a hospital. In this

situation the medical records in the hospital or from the physician and the records from the Visiting Nurse Service would apply to the same illness and may be reported together on one form. If this is the case both appropriate boxes should be checked.

The fifth category "Other" refers to any other source of recorded medical information such as consulting psychologist, social worker, or adoption agency records.

Item 6, Name and Address if Other than Study Facility. If any category other than #0 "Study Facility" is checked in Item 5, the name and address of the hospital, clinic, private physician, visiting nurse service, etc. should be given. If only "Study Facility" is checked, no recording is necessary in this space.

Item 7, Record Number. If this form is being used for a summary of medical records from the Study Hospital, the identification of this record may be contained in the patient identification stamp (Item 1). If the patient's name or record identification code or number are different from those in Item 1 or do not appear in Item 1, they should be recorded in this space.

If the record is from an outside source, the unit number, code, or name necessary to positively identify that record should be recorded in this blank. This is important in order that it may be possible to return at some later date to the original record for further information if necessary.

Item 8, Summary Includes Records Dated: _____ Through _____. Report in the appropriate blanks the first and last dates appearing on the records being summarized. If there is only one date, record it in the first blank and indicate that there were no subsequent records available (i.e., May 7, 1959 only).

The dates reported in these blanks should include all available records applying to the illness summarized.

Item 9, Age of Child at Onset of Illness. Here record the age of the child at the time the illness for which this record is being prepared was first noticed, or in retrospect first became manifest. For acute conditions this would usually correspond very closely to the first date recorded in Item 8. However, for chronic illnesses or congenital conditions this will not necessarily be the case. As a guideline for the detail desired, the following are suggested: (a) If the age is under four months report in weeks; (b) If the age is under two years report

18 months; (c) If the age is over two years report to the nearest year or half year. This is a suggestion, and the availability of information may make more or less detail desirable.

Item 10, Duration of Illness. Here report the approximate duration of the illness from the age at onset to the age at complete recovery or return to normal. For acute conditions this will usually be clear; however, for chronic, mild, or congenital conditions this may either not be clear or may continue to the present. If the condition is still present write "To the present" in this blank. ("The present" will be the second date reported in Item 8).

Item 11, Diagnosis. Here report as clearly as possible the major and all ancillary diagnoses of this illness. As nearly as possible the diagnoses should be expressed in standard medical terms such as those used in the Standard Nomenclature of Diseases and Operations.

Item 2a, Do Not Use This Space. This space is to be used by special NINDB coders for coding the diagnoses. Please do not write in this space.

Item 12, Salient Features of Illness or Condition. Record in narrative or outline fashion a very brief summary of the important features of the illness or condition. Special attention should be given to manifestations and complications of severe dehydration, technique and complications of general anesthesia, results of procedures involving the central nervous system (skull films, L.P., EEG, PEG), and positive neurological findings on examination or history. In most cases it is not necessary to list all laboratory findings, details of therapy, or details of physical examination findings.

Four sample records are included in the appendix to this manual as guidelines for the type of data desired on this record.

Items 13-23, In Addition to Summary, Check Below All that Apply to the Illness. The examiner is asked to code the presence of certain features of the illness that are considered of particular relevance to Central Nervous System disease, in addition to stating and describing them in the narrative summary. The presence of these items on the far right in no way implies that the summary should be limited to these features. Although there are many other particular features of illnesses that might have been included, this list was adopted, after careful consideration of all recommendations, for use on both Page 4 of PED-20 and on this record.

Although it is difficult to provide a concise definition for most of these items, some guidelines are suggested.

Item 13, "High fever" should be considered any temperature as high as 103°F rectally, or 102°F orally. A prolonged fever which does not quite reach this arbitrary level may also be reported as "High fever." In the blank adjacent to this item report the maximum temperature recorded and indicate whether it was rectal or oral.

Item 14, "Convulsions" should be checked if the record reports "convulsions" or "seizures," or describes tonic or clonic movements associated with disturbance of consciousness. Any description suggesting a diagnosis of convulsions should also be reported.

Item 15, "Unconsciousness" should include stupor but not mild drowsiness. This sign should be unequivocal and needs no further definition here.

Item 16, "Diarrhea" is difficult to define, but as a rough guideline four or five watery stools per day for more than one day should be considered diarrhea.

Item 17, "Dehydration" should be checked if there was clinical evidence of hemoconcentration or loss of body fluids sufficient to require parenteral fluid therapy. However, there may be appreciable dehydration described without reported evidence of hemoconcentration, and adequately treated by oral fluids. This, too, should be reported. Dryness of the skin, per se, is usually not adequate clinical evidence for significant dehydration.

Item 18, "Draining ear" should include either serous or suppurative discharge from the middle ear. Otitis without perforation should be described in the narrative summary, but not coded here.

Item 19, "Cyanotic spells" should be checked if there is either episodic or persistent cyanosis, even of the hands or feet. While peripheral cyanosis (of the hands and feet only) is sufficiently common in the newborn nursery to be of questionable meaning, it is probably worth reporting in a child beyond the newborn period.

Item 20, "Reaction to injections" should include both febrile and allergic reactions to drugs or biologicals (vaccines or antisera) given by injection. Reactions to oral medications should be described in the narrative summary, but not coded here.

Item 21, "Spinal tap" should include any procedure involving insertion of a needle into the spinal or cranial cavity, i.e. ventricular tap, subdural tap, pneumoencephalogram, etc. The results of the procedure should be specified in the summary.

Item 22, "X-ray or fluoroscopy" is self-explanatory. The X-ray report may be summarized on this record, or a copy of the original report attached.

Item 23, "Operation" should be checked for only those surgical procedures involving general or spinal anesthesia, or resulting in a diagnostic biopsy. The former is of interest for its possible influence on later Central Nervous System function. Techniques and any complications should be clearly specified. The latter is of interest, of course, in providing or ruling out a diagnosis. The pathology report may be summarized on this record, or a copy of the original report attached.

VI. CONTINUATION

If the space on this record is inadequate to record all the information considered pertinent to this illness, continue on Form CP-5, Continuation Sheet.

VII. SENDING THE FORM TO OUTSIDE PHYSICIAN FOR COMPLETION

In those situations where it is felt by local personnel to be desirable to send the form "Summary of Medical Records" to a private physician or other medical facility, rather than requesting an abstract or copy of the records, it is strongly recommended that a letter on local Study letterhead accompany the form. This letter should explain the purpose of the request and give very brief directions as to the type of information desired. Items 1, 5, and 6 should be completed by Study personnel prior to sending the form out. Items 8, 9, and 10 may be filled in by Study personnel prior to sending the form out if this information is definitely known. However, if the dates are in doubt it is probably best to leave these to be filled in by the person completing the form.

One or more copies of record form CP-5 properly identified should be included with the record form PED-29, abbreviated manual and letter to the outside physician.

January 1961

VIII. APPENDIX

Attached are four sample records to serve as guidelines for the type of data desired; and suggestions for a form letter for use in requesting medical records from an outside hospital, a form letter for use in introducing and explaining the purpose of Form PED-29, and a one-page manual to assist in reporting the type of information desired on PED-29 if it is sent out.

Date:

Hospital Administrator
(Address)

Dear _____:

As you know, the _____ is directing a Child Growth and Development Project in conjunction with several hospitals throughout the country and the National Institute of Neurological Diseases and Blindness.

We are informed that the undermentioned patient has been hospitalized at your hospital, and we would very much appreciate a copy of the discharge summary.

We will be very grateful for your cooperation, as the success of our whole program depends on the completeness of our records.

If there are any questions concerning our Study, please do not hesitate to call.

Yours sincerely,

(Coordinator's title)

PATIENT:

Name: Birth Date:
Mother's name:
Address:

Date admitted:

(local Study letterhead)

Date:

(inside address)

Dear Dr. _____:

Your patient _____, the child of _____, was seen by a member of our staff on _____. As you know this child is a participant in the _____. A history of the following illness(es): _____ seen and treated by you on or about _____ was obtained from _____ as part of our Study follow-up program.

We would be grateful for your cooperation in providing us with a summary of the pertinent features of this child's illness(es). The enclosed form is provided for your convenience in recording this information. If it would be more convenient for you to have a photocopy of your records made and sent to us that would be fine.

Thank you very much for your cooperation.

Sincerely yours,

(Pediatric Coordinator)

Enclosures: (stamped, pre-addressed envelope, Form PED-29, Page of instructions for Form PED-29, Continuation Record Sheet CP-5).

January 1961

Abbreviated Manual to be sent to non-Study medical facility

The purpose of the accompanying forms (PED-29 and CP-5) is to provide for convenience in recording in a systematic fashion a brief summary of medical information on the diagnosis, treatment, and outcome of any potentially serious disease or condition in a Study baby.

Instructions and Definitions for Reporting Information on Form PED-29

Item 7, Record Number. Record the name, number or code by which the patient's record is identified by the physician or outside hospital.

Item 8, Summary Includes Records Dated ___ through ___. Record the dates which include all records summarized in this report.

Item 9, Age. Record approximate age of the child at onset of illness.

Item 10, Duration of Illness. If the condition is congenital or chronic, or if recovery is not complete at present write "to the present" in this blank.

Item 11, Diagnoses. Record the major and any auxiliary diagnosis pertaining to this illness. It is desirable that standard medical terms such as those used in the Standard Nomenclature of Diseases and Operations be used.

Item 12, Salient Features of Illness or Condition. Record in narrative or outline fashion a very brief summary of the important features of the illness or condition. Special attention should be given to manifestations and complications of severe dehydration, techniques and complications of general anesthesia, results of procedures involving the Central Nervous System (skull films, L.P., EEG, PEG), and positive neurological findings on examination or history. In most cases it is not necessary to list all laboratory findings, details of therapy, or details of the physical examination.

Items 13-23. The examiner is asked to code the presence of certain features of the illness that are thought to be of particular relevance to Central Nervous System disease. The presence of these items on the far right in no way implies that the summary should be limited to these features. As an illustration of the type of information desired the following guidelines are suggested.

"High fever" should be coded if the temperature was over 103° rectal or 102° oral, or perhaps somewhat less if prolonged. "Diarrhea" should be coded if the child has had more than four or five liquid or copious stools for more than one day. "Dehydration" should be checked if there is evidence to suggest appreciable hemoconcentration or loss of body fluid sufficient to require intensive oral or parenteral fluid therapy. "Draining ear" should be checked only if there was otitis with perforation. Otitis without perforation should be described in the summary but not coded here. "Reaction to injections" should include both febrile and allergic reactions to antibiotics or biologicals administered parenterally. Reactions to oral medications or toxins should be described but not coded here.

Continuation. Please do not feel restricted to the single sheet (PED-29) if more extensive information is pertinent. The enclosed sheets (CP-5) are provided for your convenience.

COL-3000-29
1-61

SUMMARY OF MEDICAL RECORDS OF ILLNESS OR HOSPITALIZATION

1. PATIENT IDENTIFICATION
Whitehall, Amy
[illegible] 7/20/[illegible] Sex.
[illegible] C. D. S. Ant. Ind.

2. SUMMARY DONE BY
B. D. Kelly

3. TITLE OR AGENCY
C. D. S. Fed.

4. DATE OF SUMM.: Mo. 12 | Day 22 | Year 60

5. SOURCE OF MEDICAL RECORDS
- [X] a. Study Facility
- [ ] b. Other Hospital or Clinic
- [ ] c. Private Physician
- [ ] d. Visiting Nurse Service
- [ ] e. Other (Specify)

6. NAME AND ADDRESS IF OTHER THAN STUDY FACILITY

7. RECORD NUMBER
(Local govt. administration name, number or code if different from Item 1 above)

8. SUMMARY INCLUDES RECORDS DATED			9. AGE OF CHILD AT ONSET OF ILLNESS	10. DURATION OF ILLNESS
Mo. / Day / Year	Through	Mo. / Day / Year		
Sept. / 22 / '60		Nov. / 8 / '60	1 month	to present

11. DIAGNOSIS
1) Pneumonia, chronic, etiology unknown, 2) failure to thrive, 3) anemia, iron deficiency

11A. (Do not use abbreviations)

12. SALIENT FEATURES OF ILLNESS OR CONDITION (Brief summary of signs and symptoms, results of tests and procedures, treatment, course and complications)

1) Pneumonia age 1 mo.
Cass Lks Hosp. for 2 wks.
Adm. to UMH 9/22/60
bilateral pneumonia by X-ray, afebrile
T.B. workup neg. to date, AFB cultures pending
deep mycosis skin tests neg.
C.S.F. protein 94, cells 3, sterile

2) Thin, chronically ill, Wt. 4120 gms.
Wt. gain 400 gms. in 6½ wks. in hospital
subdural taps X2 neg.
bone age films, I.V.P. neg.

3) Hemoglobin 9.6 - 8.3 gms., assumed to be nutritional

Discharged with persistent infiltrate Rt. base
no Rx. for failure to thrive
Rx. Fer-in-sol and vitamins
P.H. Nurse will follow
return 1 mo. to clinic.

See attached discharge summary for more detail.

(Note: These three conditions are summarized together since they seem to be related and are parts of the same hospital course. In general, the records will make more sense and be easier to process if conditions or diagnoses that are related are reported together, and separate or unrelated conditions are reported on separate sheets.)

IN ADDITION TO SUMMARY, CHECK BELOW ALL THAT APPLY TO THIS ILLNESS.

- [ ] 12. High fever Max. _____ °F.
- [ ] 13. Convulsions
- [ ] 14. Unconsciousness
- [ ] 15. Diarrhea
- [ ] 16. Dehydration
- [ ] 17. Crossing eyes
- [ ] 18. Cyanotic spells
- [ ] 19. Reaction to injections
- [X] 20. Spinal tap
- [X] 21. X-ray or fluoroscopy
- [ ] 22. Operation

(Continue on Form CP-3, Continuation Sheet)

COL-3004-36
1-61

SUMMARY OF MEDICAL RECORDS OF ILLNESS OR HOSPITALIZATION

1. PATIENT IDENTIFICATION
Zolotkis, Chyye
19-[illegible]-10 10/1-/5[illegible]
F. 2[illegible] Cres. . W.

2. SUMMARY DONE BY
R. S. MacIntyre

3. TITLE OR POSITION
C.D.P. Fed.

4. DATE OF SUMM. Mo. 9 Day 27 Year '60

5. SOURCE OF MEDICAL RECORDS
- 1 Study Facility
- 2 Other Hospital or Clinic
- 3 Private Physician
- 4 Visiting Nurse Service
- 5 Other (Specify)

6. NAME AND ADDRESS OF OTHER THAN STUDY FACILITY
City Health Clinic
7th and D, S.W.
Providence, R. I.

7. RECORD NUMBER 32-103-41
(Local patient identification number, number or code of abstract from item 1 above)

8. SUMMARY INCLUDES RECORDS DATED

Mo.	Day	Year	Through	Mo.	Day	Year
7	20	'60		8	24	'60

9. AGE OF CHILD AT ONSET OF ILLNESS: 9 mo.

10. DURATION OF ILLNESS: 5 wks.

11. DIAGNOSIS
Purulent Otitis Media A.D., recurrent

11A. (Do not use this space)

12. SALIENT FEATURES OF ILLNESS OR CONDITION (Brief summary of signs and symptoms, results of tests and procedures, treatment, course and complications)

U.R. and low-grade fever 3 days, then drainage A.D. 7/20/60
Rx. 300,000 u. Bucillin I.M., Textrex drops 100 mg/day for 10 days.
Slow response, healing of drum.

Recurrence 8/1?/60
Rx. Ilosone drops 50 mg t.i.d. for 8 days

IN ADDITION TO SUMMARY, CHECK BELOW ALL THAT APPLY TO THIS ILLNESS

13. ☐ High fever Max. _____ °F.
14. ☐ Convulsions
15. ☐ Unconsciousness
16. ☐ Diarrhea
17. ☐ Dehydration
18. ☒ Draining ear
19. ☐ Cytomatic spells
20. ☐ Reaction to vaccinations
21. ☐ Spinal tap
22. ☐ X-ray or fluoroscopy
23. ☐ Operation

(Continued on Form C.P.-3, Continuation Sheet)

CDL-3000-29
1-61

SUMMARY OF MEDICAL RECORDS OF ILLNESS OR HOSPITALIZATION

1. PATIENT IDENTIFICATION
Jones, Patrick
[illegible]

SUMMARY DONE BY
J. R. Paluson, M. D.

3. TITLE OR POSITION
Family physician

4. DATE OF SUMM.: Mo. 10 | Day 19 | Year 60

5. SOURCE OF MEDICAL RECORDS
- ☐ Study Facility
- ☐ Visiting Nurse Service
- ☐ Other Hospital or Clinic
- ☐ Other (Specify)
- ☒ Private Physician

6. NAME AND ADDRESS OF OTHER THAN STUDY FACILITY
Dr. J. R. Paluson
7213 Adjacent Ave., Warwick, R.I.

7. RECORD NUMBER Name, as above
(Local patient identification name, number or code if different from Item 1 above)

8. SUMMARY INCLUDES RECORDS DATED

Mo.	Day	Year	Through	Mo.	Day	Year
5	3	'60		5	28	'60

9. AGE OF CHILD AT ONSET OF ILLNESS: 8 mo.

10. DURATION OF ILLNESS: 3 wks.

11. DIAGNOSIS
1) Bronchitis, 2) Iron deficiency anemia
3) Normal X-ray examination of hips (ruled out congenital hips)

12. (Do not use this space)

13. SALIENT FEATURES OF ILLNESS OR CONDITION (Brief summary of signs and symptoms, results of exams and procedures, treatment, course and complications)

1) Cough for 3 days, fever (est. 103°F) for 12 hours.
Rx. Tempra and Tetracyclene
Recovery ok

2) Appeared anemic, Hgb. not done
Rx. Fer-in-sol
failed to return for follow-up exam.

3) Suspicion of congenital hips on P.E.,
X-ray examination 5/28/60 read as normal,
no evidence of dysplasia of either hip.

(Note: This form was sent to Dr. Paluson for verification of the PED-20 history of bronchitis and fever. He reports two additional conditions. This is to our benefit. However, if all three conditions had been suspected from the history, a separate sheet for each condition would have made the data more convenient to process.)

IN ADDITION TO SUMMARY, CHECK BELOW ALL THAT APPLY TO THIS ILLNESS.

- 13. ☒ High fever Max. 103 °F. 12 hours
- 14. ☐ Convulsions
- 15. ☐ Unconsciousness
- 16. ☐ Diarrhea
- 17. ☐ Dehydration
- 18. ☐ Crossing eyes
- 19. ☐ Cyanotic spells
- 20. ☐ Reaction to injections
- 21. ☐ Spinal tap
- 22. ☒ X-ray or Fluoroscopy
- 23. ☐ Operation

(Continue on Form CRF, Continuation Sheet)

CDL-S005-59
7-61

SUMMARY OF MEDICAL RECORDS OF ILLNESS OR HOSPITALIZATION

PATIENT IDENTIFICATION

[illegible]

SUMMARY DONE BY

[illegible]

1. TITLE OF PERSON — C.D.P. Nurse

2. DATE OF SUMM. — Mo. 11 | Day 16 | Year '60

3. NAME AND ADDRESS OF OTHER THAN STUDY FACILITY

4. SOURCE OF MEDICAL RECORDS
- ☐ Study Facility
- ☐ Visiting Nurse Service
- ☐ Other Hospital or Clinic
- ☐ Other (Specify)
- ☐ Private Physician

7. RECORD NUMBER
(Local patient identification number, number or code of different from Item 1 above)

8. SUMMARY INCLUDES RECORDS AS FAR BACK AS THIS

Mo.	Day	Year	Through	Mo.	Day	Year
10	28	'60	only			

9. AGE OF CHILD AT ONSET OF ILLNESS — 14 mo.

10. DURATION OF ILLNESS — 2 wk.

11. DIAGNOSIS — Measles

11a. (Do not use abbreviations)

12. SALIENT FEATURES OF ILLNESS OR CONDITION (Brief summary of signs and symptoms, results of tests and procedures, treatment, course and complications)

Measles last week of Sept. reported by mother. Older brother and neighbor children had measles in early Sept., so Dr. seems ok. Not seen by doctor. Illness apparently not severe, no complications.

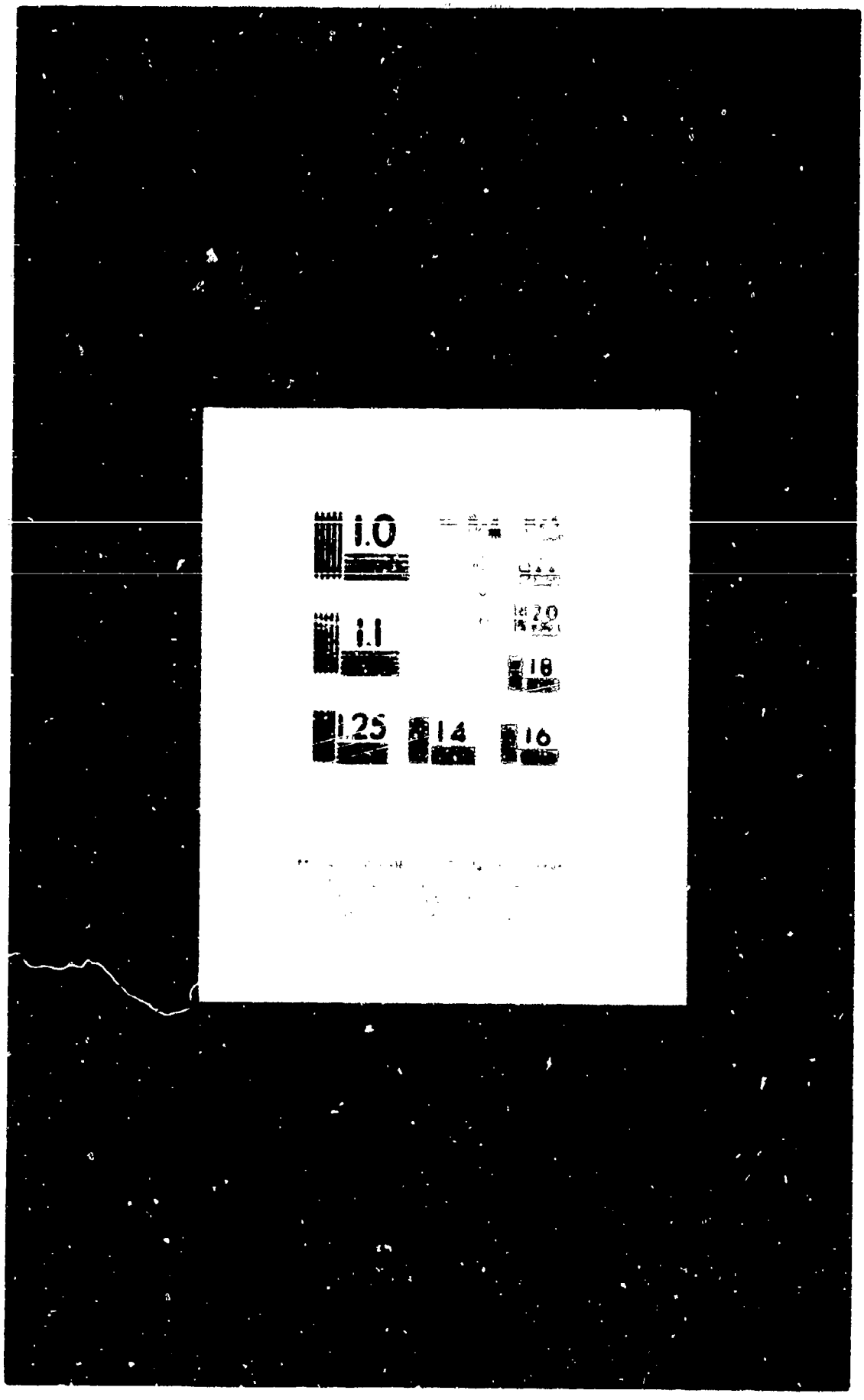
IN ADDITION TO SUMMARY, CHECK BELOW ALL THAT APPLY TO THIS ILLNESS.

13. ☐ High fever
Max. _____ °F.
14. ☐ Convulsions
15. ☐ Unconsciousness
16. ☐ Diarrhea
17. ☐ Dehydration
18. ☐ Coming out
19. ☐ Cyanotic spells
20. ☐ Reaction to medicines
21. ☐ Spinal tap
22. ☐ X-ray or fluoroscopy
23. ☐ Operation

(Continued on Form CP-1, Continuation Sheet)

Collaborative Research
National Institute of Neurological Diseases and Blindness, NIH, PHS
Bethesda 14, Md.

PED-29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CONTINUED ON NEXT FICHE